Chapter 6
Medical Family Therapy in Obstetrics and Gynecology

Angela Lamson, Kenneth Phelps, Ashley Jones, and Rebecca Bagley

The combined disciplines of obstetrics and gynecology (Ob-Gyn) are committed to the reproductive physiology of women's health throughout the lifespan and include an integration of medical and surgical care. Ob-Gyn providers attend to the social, physiological, environmental, and genetic factors that influence or exacerbate health conditions in women. As such, Ob-Gyns' expertise in and attention to diverse factors that influence the physical health of women makes medical family therapists (MedFTs) a logical partner for integrated behavioral healthcare (IBHC). Both disciplines train providers to recognize and care for the unique biopsychosocial-spiritual (BPSS) health needs (Engel, 1977, 1980; Wright, Watson & Bell, 1996) of each patient over the lifespan and in the context of her family system. Furthermore, both disciplines include training in their respective areas across prevention, health education, assessment, diagnostics, and intervention.

When collaborating, MedFTs and Ob-Gyns may resemble (at times) an IBHC team that delivers services in primary care, because Ob-Gyns oftentimes serve as a primary care provider for many women. However, there are many diagnoses and health factors that call for specialized care or surgery that are beyond what typically occurs in primary care (e.g., cesarean sections, labor, and/or delivery). Furthermore, there are unique complications that MedFTs are more likely to encounter when

A. Lamson (✉)
Department of Human Development and Family Science, East Carolina University, Greenville, NC, USA
e-mail: lamsona@ecu.edu

K. Phelps · A. Jones
Department of Neuropsychiatry and Behavioral Science, University of South Carolina, Columbia, SC, USA

R. Bagley
Department of Advanced Nursing Practice and Education, East Carolina University, Greenville, NC, USA

T. Mendenhall et al. (eds.), *Clinical Methods in Medical Family Therapy*, Focused Issues in Family Therapy, https://doi.org/10.1007/978-3-319-68834-3_6

working within departments of obstetrics or gynecology (e.g., endometriosis, pelvic pain, stillbirths) than would typically be encountered in a primary care office setting. Below is just one example of how gynecology, obstetrics, and MedFT have interfaced in one family's life.

Clinical Vignette

[Note: This vignette is a compilation of cases that represent treatment in obstetrics and gynecology. All patients' names and/or identifying information have been changed to maintain confidentiality.]

Jill was referred to a MedFT (known to have worked with several families who had experienced fetal loss) after the loss of her twins at 20 weeks' gestation, one boy and one girl. She shared her story with the MedFT about how she believed that the difficulties in this delivery had led to complications with her fertility and her concern for future pregnancies. Jill's husband was devastated at the loss of the twins. Jill mentioned that she, too, was upset—but that her first loss was much more difficult. She said, "When we lost Isa it was harder on me; when we lost the twins that was harder on my husband, Robert."

Jill and Robert experienced their first loss experience the year before; their baby Isa was stillborn. Jill had just been to her Ob visit the week before Isa's death, and everything seemed okay. She shared with the MedFT how she was told that the baby had died, whereupon she actually left the hospital and drove home alone (overwhelmed and in shock) to get her "delivery suitcase" and then returned to the hospital to deliver Isa. She expressed rage and confusion about having to deliver the baby vaginally knowing that the baby was no longer alive. She explained how she had begged for a cesarean and struggled with every push to deliver this child. During the first MedFT session, Jill shared pictures of her beautiful baby girl. She did not have pictures of her twins but had equal care and detail in her narrative regarding her love for them. It was always an honor to this MedFT to be invited to see these pictures and to hear about the naming of couples' children. Jill and the MedFT met about twice a month over a 10-month time frame.

The MedFT did not have the opportunity to meet Robert until the next spring, during a ceremony that is held each year for children who have died prior to or shortly after their birth. Both Jill and Robert were overcome by emotion during the ceremony as they read Isa's name and the names their twins, Jackson and Jenna. It was through the time together in MedFT sessions that Jill and Robert decided to memorialize their twins by giving them each a unique first name. They had not been able to take this step immediately after the twins' death.

Shortly after the naming ceremony, Jill and Robert were determined that they would try to seek fertility treatments to assist in their future pregnancy. Jill described for the MedFT how she visited a new provider who did not

*review her chart prior to the medical visit; this provider came in with questions that were painful after experiencing the loss of two children to miscarriage and one to stillbirth (*e.g.*, "Do you have any children?"). Following that experience, the MedFT reached out to the team of providers and recommended that a special flagging system on the medical chart be implemented so that providers and team members who worked with similar patients would be aware that a child's death had occurred. This collaborative action helped to reduce Jill's frustration and sadness as she faced the next provider who was more informed about her medical history.*

At this point, the MedFT began working even more closely with Jill's new Ob-Gyn. Over the next few years, Jill and Robert tried multiple times to get pregnant and, at one point, faced an ectopic pregnancy that nearly ended Jill's life. Jill lost a lot of blood prior to hospitalization, and Robert began to worry about the well-being of his wife if they chose to continue with fertility treatments.

After this experience, Jill, Robert, the Ob-Gyn, and the MedFT met to discuss the couple's plans for proceeding since the scare of the last pregnancy. Together, the team continued to reflect on Jill's biopsychosocial-spiritual well-being, Jill's and Robert's relationship as a couple, and the collaborative work needed among all of Jill's personal and professional healthcare team. Jill had made it clear to the MedFT many times in the past that all she wanted in the world was the one thing that she could not seem to have: to give birth to a live baby. Jill understood her husband's concerns about not wanting to continue with their attempts, but she wanted so desperately to share the experience of childbearing and rearing with Robert.

Throughout the following months, Jill and Robert worked with their Ob-Gyn and a well-respected perinatologist with a final hope for pregnancy. Jill was not far into her pregnancy when it was determined that she should be on bed rest. Her status eventually became so high risk that she was transferred to a local hospital, where she would stay until the birth of their baby. During the 3 months that Jill was on hospitalized bed rest, there were a number of collaborators who worked together to ensure a safe and successful delivery. Providers included the perinatologist, women's health care teams, a number and variety of nursing professionals, the MedFT, and nearly a dozen other types of providers/staff. The MedFT would call Jill, or stop by to see her, to hear how she and Robert were doing, and to provide as much support as possible for the two of them. She and the MedFT had a number of conversations about the "What if?" questions that invaded her thoughts every day. Jill and the MedFT also talked about how she could strengthen her attachment to the unborn child and what she would want this baby to know about the brother and sisters who had come before her.

Finally, after years of struggling, Jill and Robert had a beautiful baby boy. To this day, that little boy is called a "miracle baby." Following multiple losses, Jill and Robert had an incredible experience to share with the world.

The role of the MedFT in the life of this family was so small compared to what that family had contributed to the healthcare system (e.g., better ways to identify fetal loss in the electronic health record and feedback regarding what was most helpful during the stay in the hospital following such losses). However, there were some skills implemented by the MedFT that were essential to working with this family. It was critical for the MedFT to know:

1. What a stillbirth is
2. The significance of memorializing a baby who has died (e.g., offering a naming ritual, sharing pictures)
3. What parents who have had a miscarriage or stillbirth encounter via biopsychosocial-spiritual conversations with friends, family, and providers who may or may not be helpful
4. The unique biopsychological-spiritual strains felt by mothers compared to those experienced by fathers
5. How to collaborate with Ob-Gyn providers and families when they consider or plan for future pregnancies following a loss experience

Jill has since collaborated with MedFTs on some state level presentations for providers (mostly labor and delivery, women's health, psychiatry, marriage/couple and family therapy, and MedFT) to teach others more about the biopsychosocial-spiritual influence of miscarriage and stillbirth experiences in a parent's life. Together, they (Jill and the MedFTs) have discussed the systemic challenges of such circumstances, the collaborators that were (are) necessary in Jill's life or those like her, things that were helpful and not helpful in care, and resources for medical and behavioral health providers to consider when caring for families who experience a miscarriage or stillbirth. The remainder of this chapter provides more details into the roles that Ob-Gyn teams and MedFTs extend to a diverse range of issues and patients encountered in an Ob-Gyn practice.

What Are Obstetrics and Gynecology?

Ob-Gyn practices have become a healthcare home for many women across the United States. This is not surprising, given that women meet with their Ob-Gyn provider throughout the life cycle. Some young women may first come to an Ob-Gyn at the onset of menarche to ensure that all biological systems are healthy. With the heightened attention to some vaccinations (e.g., Gardasil) and potential health consequences for human papilloma virus, some young women may arrive at an Ob-Gyn even before menarche to learn about sexual health and the prevention of a number of health conditions beyond those that directly relate to sexual activity.

Ob-Gyns are continuously using research to inform their practice, which also helps to ensure that care is cost-effective for patients. For example, young women do not commonly receive a Pap smear now until the age of 21, and then the exam may only be done every 3 years unless the results are abnormal. Women who are of

a reproductive age may receive exams annually in order to request or maintain birth control, be screened for sexually transmitted diseases, and/or ensure that there have been no changes in their health (Osborne, 2017). While many visits to Ob-Gyns may be for preventative care, some appointments are prompted by changes to women's biopsychosocial systems including heavy, prolonged, or irregular menstruation, chronic pelvic pain, typical or atypical changes due to pregnancy, and/or challenges associated with mental health—perhaps in association with developmental shifts such as menarche, pregnancy, post-pregnancy, and menopause.

As stated above, one common concern for women is related to menorrhagia or heavy bleeding, which often leads to the discovery of hormonal imbalances, ovarian dysfunction, polycystic ovary syndrome, uterine fibroids, or polyps (Ahuja & Hertweck, 2010). During an initial or follow-up evaluation, concurrent discussions about mood may arise for some adolescent or adult women. Inquiry into mood states can identify premenstrual dysphoric disorder for up to 5.8% of menstruating women, which is characterized by impaired affective lability, irritability, low mood, and anxiety during the final week before the onset of menses (American Psychiatric Association, 2013). Undoubtedly, these mood changes reverberate through the family system, prompting relational tension for parents, partners, or other family members. Unfortunately, challenges with menorrhagia can exacerbate or be exacerbated by psychosocial challenges that can result in or exist in tandem with chronic pelvic pain (Shin & Howard, 2011; Stein, 2013).

Chronic pelvic pain, commonly defined as noncyclical pain that lasts greater than 6 months, is estimated to occur in 5.7–26.6% of women (Ahangari, 2014). The development and course of genito-pelvic pain remains unclear, particularly because there are commonly reported delays in seeking care and, as such, the initial source of pain may have grown or evolved in uncertain ways. Peaks of reported pain are commonly seen in early adulthood (related to onset of sexual activity) and during perimenopause due to physiologic changes (American Psychiatric Association, 2013). Similar to most pain conditions, the existing literature supports the best practice of treating pelvic pain by using a biopsychosocial stance whereby disease activity, physical condition, self-efficacy, cognitive experience, social support, and relational adjustment can be conceptualized concurrently (Tripp & Nickel, 2013). The assortment of services (e.g., medical, surgical, physical, and psychological treatments) needed by patients to manage pain can all be provided via an IBHC or collaborative care model whereby Ob-Gyn and MedFT providers can work in tandem to extend both BPSS and relationally based interventions as part of acute and complex chronic care (Al-Abbadey, Liossi, Curran, Schoth, & Graham, 2016).

Alongside onset and abnormalities in menarche as an initial foray into gynecologic care, many young women seek care from an Ob-Gyn provider with the desire to start or consider contraception based on their sexual health needs (Osborne, 2017). Of course, contraceptive counseling is not confined to early life, as many women remain on some form of contraception for decades (Murphy, Hewitt, & BeLew, 2017). Best practices exist to ensure that contraceptive counseling incorporates relational- and task-oriented communication grounded in a close, trusting patient-provider relationship (Dehlendorf, Krajewski, & Borrero, 2014). Visits

addressing contraceptives often include valuable psychoeducation about anatomy and sexual response, as well as discussions regarding safe sex practices throughout the life cycle (Berishaj, 2017; Cason, 2017). The American College of Obstetricians and Gynecologists (2011) recommends screening for prior sexual abuse, rape trauma histories, and current or past intimate partner violence for every patient. Detection of an assault history during contraceptive counseling can ensure timely referral to psychotherapeutic services to advance psychological healing and combat post-traumatic stress symptomatology. Identification of sexual dysfunction (e.g., low desire, genito-pelvic pain, anorgasmia) during annual examinations is another common topic of concern that activates involvement of a behavioral health provider. These opportunities lend themselves to MedFTs using their systemic lens to analyze the interplay of medical, psychological, and relational factors associated with intimacy and/or intercourse.

Perhaps the most widely seen and known presentations within Ob-Gyn offices relate to women during pregnancy and postpartum periods; these encompass a variety of positive and concerning BPSS stressors. With nearly four million babies born each year in the United States (Martin et al., 2011), there is an abundance of healthcare visits that take place to ensure the safest health measures possible for mother and child throughout and following the pregnancy. At times, women and their partners bear the burden of infertility, characterized by financial duress, lowered moods, and mounting anxieties (Luk & Loke, 2015). The experience of infertility has also been linked to relational problems, including communication difficulties and/or sexual dysfunction (Monga, Alexandrescu, Katz, Stein, & Ganiats, 2004). While most women do not have difficulty becoming pregnant, the role of expected versus unexpected pregnancy may influence mental wellness. In fact, nearly half of pregnancies in the United States are unintended (Finer & Zolna, 2011). This unexpected life event can cue difficult decision points regarding parenthood, abortion, or adoption wherein the safe spaces provided by an Ob-Gyn provider and/or MedFT could be both welcomed and warranted.

For women who continue in their pregnancies, the hormonal fluctuations during the perinatal experience coupled with the demands of this transition into a new role can cue new relational distress or postpartum symptomatology (Wenzel & Kleiman, 2015). The nature of perinatal psychological distress is detailed later in this chapter given the prevalence of this concern within the inpatient and outpatient contexts, including more information pertaining to pregnancy loss via miscarriage and stillbirth. Relational distress is also to be expected in light of the fact that pregnancy and birth are relational experiences; relational factors are described throughout this chapter.

MedFTs, given their systemic stance and focus on life cycle issues, are ideal practitioners for integrated Ob-Gyn contexts. Concerns can range from those outlined above to the discovery of congenital abnormalities on ultrasound, attachment difficulties with a new baby, co-occurring urological problems (e.g., incontinence, interstitial cystitis), vasomotor symptoms of menopause, and intimate partner violence. Regardless of the chief complaint, the psychological and relational nature of

Ob-Gyn practice is evident. While systemically oriented behavioral health providers are a vital part of the treatment team, an array of service providers are needed to assess and treat the complex issues within women's healthcare.

Treatment Teams in Obstetrics and Gynecology

There are many possible members of a treatment team that play an integral role in patient care across an Ob-Gyn practice. The key participants will likely depend on the setting (outpatient versus inpatient), life stage of the patient (adolescent, reproductive years, menopause, postmenopause), and the resources of the office or facility. If there is a physician or physician extender on the treatment team, he or she will typically serve as a medical director of the practice or unit, though all members of the team have distinct and important roles to play in caring for women on the Ob-Gyn service. The goal of the team should be to provide comprehensive and evidence-based care for each patient (including relevant family/social support).

Advanced practice registered nurses (APRN): Nurse practitioners, nurse anesthetists, clinical nurse specialists, and nurse midwives. APRNs have a wide variety of duties within the healthcare setting, including taking histories, performing physicals, counseling patients, making diagnoses, performing procedures, ordering tests, and—in most states—prescribing medications. They are registered nurses with advanced training in a specific field of study. APRNs have a minimum of a master's degree and some have a doctorate in nursing practice. Depending on the state, they may practice independently (consulting with physicians, nurse practitioners, and physician assistants as needed). Certified nurse midwives (CNMs) are trained to provide care for women from adolescence through postmenopause with a focus on labor and birth. They are also trained in the care of the "well" newborn for the first 28 days of life.

Behavioral health providers (BHPs). Behavioral health providers are represented by a number of mental health disciplines within Ob-Gyn settings, including MedFTs, psychologists, social workers, counselors, and psychiatric nurses. These mental health professionals work collaboratively with other healthcare professionals to ensure the delivery of comprehensive, biopsychosocial-spiritual care. BHPs commonly use brief screening, assessment, and treatment models to address adherence, psychological distress, coping difficulties, and relational tension associated with biological or physical wellness, illness, or life-changing experiences (e.g., pregnancy). Diagnosing and intervening at the individual, couple, or family level, providing group therapy, and referral to specialty care for more in depth psychological treatment are also typical functions for BHPs. MedFTs who serve as the BHP will especially focus on assessments, diagnoses, and interventions that are BPSS and relational in nature. Chaplains, religious counselors, and clergy are often consulted in the event of a maternal or fetal death.

Doulas. A doula is a nonmedical person who provides physical, emotional, and informational support during prenatal care and during childbirth. Additionally, postpartum doulas are trained or experienced in providing postpartum care, including care for the mother and newborn, breastfeeding support, cooking, child care, errands, and/or light cleaning. While there are no specific licensing requirements for being a doula, many have completed a seminar and course or have extensive hands on training in maternal and infant care, leading to certification for some.

Genetic counselors. Genetic counselors inform patients and healthcare providers about the risks of inherited conditions before, during, and after pregnancy. These counselors perform detailed histories and often include genograms in their assessments to determine familial patterns of illness or medical conditions. As part of the counseling, options for genetic testing are frequently discussed with a hybrid of information and support offered throughout. Genetic counselors usually hold master's degrees or have completed certificate programs in genetic counseling and are called upon in prenatal settings to discuss abnormal ultrasound findings or when prenatal tests reflect abnormalities.

Lactation consultants. Lactation consultants are members of the healthcare team who provide patients with lactation and breastfeeding care and support often in inpatient settings and during the postpartum period. Typically, lactation consultants have become certified after education in other fields, such as nursing or midwifery. Lactation consultants must have demonstrated education in health sciences before taking the examination to be certified by the International Board of Lactation Consultant Examiners.

Medical assistants (MA). Medical assistants perform clinical and administrative work in various healthcare settings. They take vital signs, schedule appointments, enter patient history or information into the medical record, handle laboratory samples, and in some states can administer medications or injections as ordered by the primary care provider. MAs have completed high school, and many complete a certificate program, while others begin working and learning through clinical experience.

Neonatologists. Neonatologists are medical doctors (M.D. or D.O.) who specialize in treating critically ill infants in the neonatal intensive care unit (NICU). Neonatologists have completed undergraduate school, 4 years of medical school, 3 years of pediatrics residency, and an additional 3 years of a Neonatal-Perinatal Medicine Fellowship.

Obstetrician-gynecologists (Ob-Gyn). Ob-Gyns are medical doctors (MD or DO) who specialize in the medical and surgical care of women. According to the American Congress of Obstetricians and Gynecologists (2005), Ob-Gyns are "dedicated to the broad, integrated medical and surgical care of women's health throughout their lifespan" (para 1). Ob-Gyn physicians and extenders have completed undergraduate school, 4 years of medical school, and 4 years of obstetrics-gynecology residency training. They are licensed to practice medicine and can pre-

scribe medication and perform surgical procedures that are within their scope of practice. Resident physicians start with a limited medical license to practice medicine but can apply during residency for a permanent medical license. Some Ob-Gyn physicians and extenders further specialize after completing residency by doing a fellowship in fields like gynecologic oncology, maternal-fetal medicine, female pelvis medicine and reconstructive surgery, and reproductive endocrinology and infertility.

Palliative care coordinators. This coordinator is typically a nursing professional who provides for patients with life-threatening illnesses and their families with continuity of care through the loss experience. The coordinator often receives referrals, provides or arranges for anticipatory grief counseling, and coordinates bereavement programs.

Physician assistants (PA). Physician assistants are members of the healthcare team who work closely with physicians. The level of supervision from a physician required for PAs varies by state. PAs take patient histories, diagnose and treat illnesses, prescribe medications, and order tests. PAs typically complete 4 years of undergraduate school and then 2 years of a master's degree.

Perinatologists. Perinatologists are medical doctors (MD or DO) who specialize in the care of the fetus and complicated, high-risk pregnancies. This subspecialty is also known as maternal-fetal medicine (MFM). In addition to medical school and 4 years of Ob-Gyn residency training, the MFM specialist receives 2 to 3 years of education in the diagnosis and management of high-risk pregnancies. The MFM physician typically works in close consultation with the obstetrician.

Psychiatrists. Psychiatrists are medical doctors (MD or DO) who specialize in diagnosing, treating and preventing mental disorders, and assessing both physical and mental aspects of psychological illnesses. Psychiatrists have completed undergraduate school, 4 years of medical school, and 4 years of psychiatry residency training. They are licensed to practice medicine and can prescribe medication. Psychiatrists also receive training in psychotherapy, so they may choose to utilize psychotherapy in addition to medications for treatment of patients. Some psychiatrists further specialize after residency by doing fellowships in child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, addiction psychiatry, sleep medicine, pain medicine, or psychosomatic medicine. Some psychiatrists choose to specialize in reproductive psychiatry, which focuses on the diagnosis and treatment of psychiatric disorders related to a woman's reproductive cycle, pregnancy, and menopause.

Registered nurses (RN). Registered nurses provide patient care and education in a wide variety of patient care settings. They take medical histories, administer medications, provide instructions to patients and families about illnesses and treatments, observe patients, and help with care planning. RNs may have an associate's degree in nursing, a bachelor of science degree in nursing, or graduate from an approved program. RNs have a nursing license.

Fundamentals of Care in Obstetrics and Gynecology

At first glance, one may assume the proficiencies required of a MedFT in the treatment of women in an Ob-Gyn context may be no different than in a traditional mental health setting or primary care environment. However, women seek care during some of the most anxiety provoking and sensitive times of their lives (e.g., deciding to become sexually active, attempting to become pregnant, and transitioning into midlife). Thus, while common disorders (e.g., depression, anxiety) and relational woes may be superficially similar, the amplitude of these struggles may be higher or uniquely presented in Ob-Gyn practices given the BPSS factors at play. The physiological fluctuations and role shifts that occur during pregnancy and postpartum warrant specific mention, too. Diseases and dysfunctions that accompany sexual activity often carry substantial shame or guilt, requiring a MedFT to have as much empathy as information when joining and extending care. When working as a MedFT provider in Ob-Gyn practice, specialized content knowledge and skill sets are essential. The following represent those that are most important to this effort.

Perinatal Distress

Throughout the reproductive years, women may experience different types of mental, behavioral, or emotional issues. Given the importance of optimizing mental well-being, MedFTs should explore the time course of symptom presentation to delineate between an exacerbation and new onset of a mental illness. A pregnant or postpartum woman may experience worsening symptoms of a preexisting mental health condition, like someone who already has obsessive-compulsive disorder, and it worsens during pregnancy or in the postpartum period. Other women may have a new onset of a mental illness during pregnancy or in the postpartum period, since many mental illnesses first present during the reproductive years (e.g., young women are almost three times as likely as young men to develop depression at the onset of puberty (National Institute of Mental Health [NIMH], 2015).

The skill of determining onset of illness is best paired with an appreciation for the relational climate, specifically whether social factors precipitated, exacerbated, or could remediate a current struggle. For many women and their partners, it is not uncommon during pregnancy to have a series of complex conversations that result in partners feeling as though what may have once felt like a healthy relationship is now a relationship filled with conflict or—even worse—is one that is unhealthy or unwanted. MedFTs in Ob-Gyn practices need to have both knowledge and skills in understanding common BPSS challenges associated with pregnancy to facilitate conversations with patients and their partners or other family members and engage in healthy exchanges about complex issues. Some of the common topics that should be addressed include (a) expectations about what it is to be parent (e.g., has the parent(s) discussed parenting styles?), (b) expectations about the baby (e.g., does

the parent(s) know about normal developmental stages and engage in discussions about any special needs their infant may have?), (c) financial shifts (e.g., cost of daycare, diapers), and (d) roles of partners (e.g., if a single parent, is there adequate social support?; if partnered, have the parents each talked about how their role within the home will change and have partners talked about how to maintain their couple relationship while also maintaining their role as parents?). An incredible skill set that many MedFTs have is to assist the parent(s) with how life will change upon their child's appearance into the world. Furthermore, parents can be most successful when expectations are right sized and clearly communicated with other support systems. These conversations, when supportive, can also be essential in reducing the likelihood for perinatal distress.

Skills of a family therapist working in labor and delivery were previously outlined in a 2011 Clinical Update for the American Association for Marriage and Family Therapy. Those focused on the relational unit and treatment team include the following (Lamson & Phelps, 2011, p. 122):

1. Utilize theories to recognize and normalize family life changes amongst healthy and/or complex pregnancies and deliveries
2. Recognize that there may be unmet needs by one or both parents or disappointment with regard to expectations associated with prepared birth plans that had to change during the delivery process or complications with breastfeeding, etc.
3. Assess psychosocial trends (e.g. guilt, blame, depression) amongst families navigating complications
4. Explore ways to assist parents so that they may make difficult choices by facilitating discussions using effective communication techniques
5. Collaborate with chaplains, pastors, or priests for families with a strong religious or spiritual faith
6. Conduct small process groups to reduce compassion fatigue among providers

Healthy conversations and support are important for any patient to remediate perinatal or relational distress but may be especially central for women who are identified as lesbian, gay, bisexual, and transgender (LGBT). Discrimination may aggravate psychological health for these patients and/or serve as a barrier to receiving physical and psychosocial health services. Increasingly, LGBT couples are presenting to healthcare providers with a desire for parenthood. Unless the couple is both a transman and transwoman with intact reproductive organs, the only options for LGBT couples are adoption, surrogate pregnancy, or pregnancy with insemination. When both partners identify as lesbian, the decision about which partner is going to attempt the pregnancy and carry the child is necessary. For those who select surrogacy or adoption, there may be additional concerns beyond those experienced by heterosexual couples due to biases or discrimination against LGBT parents. Concerns for the transman—a person born with a female reproductive system who identifies and expresses himself as male (Fenway Health, 2017)—carry other important questions to consider, including decisions to stop hormone therapy so as to conceive. This decision has the potential for the return of female characteristics (Ellis, Wojnar & Pettinato, 2014).

MedFTs are ideally trained to explore these complex decisions within the patient and family's distinct social location. MedFTs working therapeutically with these families should understand the immense subjugation faced by many of these patients. Unfortunately, much of this discrimination originated in the mental health professions with conversion therapy and pathologizing of sexual or gender identities as commonplace in our histories (i.e., diagnostic codes for homosexuality in early version of the Diagnostic and Statistical Manual of Mental Disorders). However, a new generation of thought has risen, where the therapy room can offer a safe place to affirm the identities and attractions of LGBT couples who are seeking Ob-Gyn care. Offering this supportive, nonjudgmental stance for patients and their partners should be common practice, and providers should be particularly attuned to the various presentations of psychological distress during the perinatal period.

Psychological Distress During Pregnancy

Anxiety and depressive disorders have been found in up to 20% of women during pregnancy (Massachusetts General Hospital Center for Women's Mental Health, 2017). As mentioned previously, symptoms may represent challenges associated with a preexisting or a new-onset illness. In women being evaluated for postpartum depression, at least 11% had symptoms of depression during the pregnancy (Newport, Fernandez, Juric, & Stowe, 2009). Given the preponderance of mood and anxiety complaints, screening for mental health symptoms during pregnancy is important not just for the quality of life of the expectant mother but also for the family and fetus. While the assessment of mood and anxiety symptoms might be comfortable for some Ob-Gyn providers, more complex presentations that involve other mental health comorbidities, polypharmacy, or relational conflict would warrant the inclusion of the broader team, including a MedFT and/or reproductive psychiatrist. There is published literature that examines the potential developmental and obstetrical outcomes of untreated maternal mental illness on the fetus (Newport et al., 2009; Suri, Lin, Cohen, & Altshuler, 2014). Though a comprehensive discussion about the risks of untreated illness versus risks of pharmacological treatments in pregnancy is beyond this chapter's scope, it is important to highlight that not recognizing these illnesses in pregnancy can potentially have detrimental effects on the fetus and the mother.

Psychological Distress During Postpartum

In the postpartum period, it is important for MedFTs to understand several different psychiatric illnesses that may occur. In fact, estimates are as high as 85% of women who experience some type of postpartum mood change. The most common of these

is called the "postpartum blues" (or the "baby blues"). This is not usually considered a disorder because it is very common and does not typically impair a woman's functioning. Postpartum blues typically occur within the first few weeks after delivery. Women can have mood changes and become more tearful, irritable, and anxious. These struggles peak at approximately day four or five postpartum and typically remit within 2 weeks. Monitoring symptoms of postpartum depression is important, but intensive therapy or pharmacologic intervention is not usually necessary. MedFTs can utilize normalization, openly discuss recent role changes with women and their partners, and provide an outlet to ponder the delicate balance of personal time for self-care and bonding with the new baby (Massachusetts General Hospital Center for Women's Mental Health, 2017).

Postpartum depression. About 15% of patients will experience postpartum depression (PPD) (Postpartum Support International, 2016). Higher rates of depression have been found in teens and in women of lower socioeconomic status (Postpartum Support International, 2016; Postpartum Progress, 2016). Again, this highlights the understanding that the biopsychosocial-spiritual assessment of a patient is crucial in creating the most effective treatment plan. PPD can cause significant dysfunction for a new mother and often the family unit. PPD appears similar to other types of depression. Persistent symptoms may include depressed mood, sadness, little interest in activities (including the baby), feeling guilty, sleep disturbance, appetite changes, low energy, poor concentration, feeling hopeless and/or worthless, and suicidal thoughts (American Psychiatric Association, 2013). One helpful assessment for PPD is the Edinburgh Postnatal Depression Scale (EPDS); it is a validated ten-item screening tool (Cox, Holden, & Sagovsky, 1987).

It is important to recognize and treat PPD, as it potentially impacts maternal-infant bonding, infant and child development, quality of life for the mother, and stabilization of the family unit (Newport et al., 2009). Concerns regarding prenatal and postpartum depression may also extend to fathers. Paulson and Bazemore (2010) documented that approximately 10% of fathers experienced perinatal depression, which was moderately correlated to maternal depression in their meta-analysis. Thus, concerns regarding screening for these symptoms should extend to fathers and partners in LGBT relationships. The MedFT's systemic lens adds an important element to the IBHC team, as tracking the interrelationships between mood, relational cohesion, and familial conflict seems prudent. Moreover, intervention aimed at improving depressive symptoms alongside attachment bonds may hold distinctive benefits as both members of the couple are navigating this transition.

Postpartum anxiety. Postpartum anxiety is not as widely discussed as PPD but is certainly experienced by many new mothers. Women may experience excessive worry and anxious behaviors centered around their baby. Symptoms include restlessness, irritability, muscle tension, and/or insomnia. To classify these symptoms, the MedFT should be familiar with the presentations of generalized anxiety disorder, panic disorder (and/or panic attacks), and post-traumatic stress disorder (American Psychiatric Association, 2013). Many new mothers also experience distressing thoughts (e.g., unwanted, thoughts that involve harm coming to the baby)

common with anxiety and, specifically, obsessive-compulsive disorder (OCD) (Uguz & Ayhan, 2011). Data show that a vast majority of new parents have "scary thoughts," but whether they are interpreted as alarming or significant is what morphs these thoughts into obsessions that drive compulsions (Wenzel & Kleiman, 2015). These thoughts can include accidental harm or thoughts of intentional harm to the infant (Fairbrother & Woody, 2008). Intrusive thoughts of harm are different from homicidal ideation or delusions related to postpartum psychosis, as they are ego-dystonic (i.e., not aligned with one's sense of self or wishes), rather than ego-syntonic (i.e., aligned with one's current self, desires, or wishes). Noteworthy risk factors for development of postpartum-onset OCD include an obsessive-compulsive or avoidant personality, as well as a history of major depression (Uguz & Ayhan, 2011).

MedFTs should be aware of the various psychotherapeutic treatments for anxiety disorders, most notably cognitive-behavioral and mindfulness approaches, that have been shown to reduce distress for new parents (Wenzel & Kleiman, 2015). Reassurance giving should be avoided for the patient with OCD, as this is contraindicated because it tends to worsen symptomatology. Instead, exposure and response prevention (E/RP) or systematically approaching the feared stimulus without engaging in rituals or compulsions (Wheaton et al., 2016) is recommended.

Postpartum psychosis. The rarest but most serious postpartum mental illness is postpartum psychosis. Postpartum psychosis occurs in about 1–2 out of 1000 postpartum women (American Psychiatric Association, 2013). This disorder has a high risk of infanticide and suicide; it is thereby considered a psychiatric emergency that usually requires hospitalization. After delivery, women may rapidly develop symptoms (e.g., within 2 weeks). Though it is termed postpartum psychosis, the initial symptoms appear similar to bipolar disorder, including irritability, sleep disturbance, mood shifts, and restlessness. Women also may develop confusion, disorganization, auditory hallucinations, and delusions (American Psychiatric Association, 2013). It is important to ask about the baby when discussing symptoms, as the hallucinations or delusions may involve the baby (Bergink et al., 2015). An overview of the various presentations of perinatal distress along with treatment approaches is presented in the research-informed practices of this chapter (Massachusetts General Hospital Center for Women's Mental Health, 2017).

Additional Difficulties Associated with Pregnancy

While perinatal distress and concurrent relational difficulties into parenthood may be some of the most common presenting concerns for a MedFT to attend to (perhaps even more so when caring for infants who have physical health concerns or diagnoses), MedFTs may also help women (and partners) face a number of other difficulties, such as infertility, miscarriage, and stillbirth that require grieving hopes and

dreams for an idealized birth or growing family. These losses may occur in the context of serious health complications during pregnancy, including ectopic pregnancy, placenta previa, placental abruption, preeclampsia, and thromboembolic disease, among others. It is also not uncommon for some women to grieve the loss of a normal spontaneous vaginal delivery when they end up with a cesarean birth, even when mother and baby are both healthy. Below are descriptions of ways in which loss may occur throughout pregnancy.

A pregnancy loss can occur during any trimester. A pregnancy loss prior to 20 weeks' gestation is called an early pregnancy loss or a spontaneous, elective, or medical abortion. Spontaneous abortion (SAB), also known as a miscarriage, occurs in at least 10% of all diagnosed pregnancies, with 80% of these losses occurring in the first trimester (American Congress of Obstetricians and Gynecologists, 2015). This is why many pregnant women wait until they hear the fetal heartbeat at 12 weeks' gestation to announce their pregnancy. An elective abortion (EAB) is a voluntary termination of the pregnancy for nonmedical reasons. A medical reason for an EAB is called a medical abortion; it may be recommended by a healthcare provider because of the mother's poor health or a fetus with an anomaly incompatible with life. After 20 weeks' gestation, a loss of pregnancy is called a stillbirth or intrauterine fetal demise (IUFD). If the gestational age of the pregnancy is not known, a birth weight of 350 grams is used to differentiate an IUFD from a SAB (Cunningham et al., 2014).

There are numerous risk factors for a spontaneous early pregnancy loss, with 50% due to chromosomal abnormalities (Alijotas-Reig & Garrido-Gimenez, 2013; Stephenson, Awartani, & Robinson, 2002). Maternal factors for pregnancy loss may also be due to infection, medical disorders including hypertension (HTN), diabetes mellitus (DM), thyroid disorders, medications, radiation, extremes of nutrition (severe deficiency and morbid obesity), lifestyle choices (smoking, excessive caffeine, illicit drugs), occupational or environmental factors, immunological factors, inherited thrombophilias, or uterine defects (Cunningham et al., 2014).

Causes of a pregnancy loss after the first trimester may be associated with the placenta such as an abruption, fetal growth restriction with a decreased blood flow through the placenta, infections, chronic health conditions in the mother (e.g., hypertension, diabetes, or clotting disorders), and umbilical cord accidents such as a true knot or a tight nuchal cord (Jordan, 2014). Sometimes the pregnancy ends secondary to preterm labor or cervical insufficiency, during which the baby dies due to being previable (or because of complications from being born too early).

An IUFD is generally suspected during a pregnancy when there is an absence of fetal movement after it has been felt by the mother or the inability to auscultate the fetal heartbeat after it had been documented as audible. A diagnosis is not made until confirmed with ultrasonography which visualizes the absence of cardiac motion in the fetus. Once the diagnosis of an IUFD is made, the mother or couple is given options about how to proceed. Depending on the gestation of the pregnancy, these may include a medical induction or surgically evacuation. Some mothers or couples want to end the pregnancy immediately; others need time to accept the

diagnosis prior to scheduling the termination. At times, women must labor for an extended length of time after a known loss. An important area of consideration for the MedFT is possible post-traumatic stress disorder (PTSD), especially for those couples experiencing repeated losses or traumatic deliveries. Many women and their families need a safe space to process their options regarding timing and/or method of termination. MedFTs should function as a process consultant in these scenarios, providing a safe space for such considerations.

Additional Difficulties Not Necessarily Associated with Pregnancy

In addition to a variety of challenges that are associated with pregnancies, are a variety of concerns that may or may not coincide with pregnancy. Two examples of these common presenting concerns include (a) sexually transmitted infections or disease and (b) changes due to menopause.

Ob-Gyns have a significant role in screening, preventing, diagnosing, and treating *sexually transmitted infections* (STIs). Some STIs can have significant neurological implications if they are contracted during early pregnancy. STIs are infections that spread through sexual contact in both males and females. Herpes, gonorrhea, chlamydia, human immunodeficiency virus (HIV), and syphilis are a few examples of such infections. In a recent press release, the Centers for Disease Control and Prevention (CDC) reported a concern about the significant increase (and highest combined number) of chlamydia, gonorrhea, and syphilis infections (CDC, 2016). Half of the new STIs have been found in people aged 15–24 (Office of Women's Health, 2017). STIs may not be noticeable upon visual inspection and/or may not present initially with significant symptoms, but they can lead to serious health effects if not treated. Medications are used to treat STIs and may be given to both the patient and his or her partner. Some STIs can be cured with treatment; others require ongoing symptom management (Office of Women's Health, 2017). Patients who complain of vaginal or penile discharge, painful urination, genital sores, or have unprotected sexual encounters, should be examined by their health professional.

The CDC reports that the only way to avoid getting an STI is to not have oral, anal, or vaginal sex. Patients who are sexually active can decrease their risk by correctly using condoms, getting vaccinated (available for human papilloma virus and hepatitis B), or maintaining a monogamous relationship where both partners have negative tests for STIs (CDC, 2016). Education by MedFTs about STI risk, prevention, and screening is an important part of caring for women. It is imperative that MedFTs and medical professionals provide accurate and appropriate information about STIs and sexual practices, especially since the specific content of sexual education in schools (where young women are most likely to first learn about reproduction and sexual health) is variable.

Menopause is the cessation of menstrual cycles, caused by either the ovaries no longer producing estrogen (natural) or removal of the ovaries (surgical). This is considered the transition from being reproductive to nonreproductive. A fact sheet associated with menopause, related terms, and hormone therapies was created by the American College of Obstetrics and Gynecologists [ACOG] (2015). Menopause can last 4–8 years, and in the United States, the average age of menopause is 51 years old. Symptoms initially include changes in frequency and length of menstrual cycles (sometimes called perimenopause), followed by vaginal dryness and vasomotor symptoms (hot flashes and night sweats) that continue after menstrual cycles stop. Women can experience insomnia, urinary changes, and sexual dysfunction throughout menopause. Risks for osteoporosis and heart disease are increased as well. It is essential that MedFTs be aware of changes associated with menses from adolescence through menopause.

Obstetrics and Gynecology Across the MedFT Healthcare Continuum

Medical family therapists may function differently in each Ob-Gyn context based on the needs of the context, collaborative team involved, and relevance of BPSS or relational health to the environment. In some instances, MedFTs may function in one of the five levels of the MedFT Healthcare Continuum (Hodgson, Lamson, Mendenhall, & Tyndall, 2014), ranging from rarely using the BPSS framework or a relational lens with patients or providers in the Ob-Gyn system or up through the highest level of proficiency, by integrating systemic and BPSS practice, research, and policy collaboratives alongside of Ob-Gyn patients and providers. Tables 6.1 and 6.2 highlight specific knowledge and skills that characterize MedFTs' involvement in Ob-Gyn contexts across this continuum.

At *Levels 1 and 2*, MedFTs are likely to be in a context where there is minimal collaboration or opportunity to directly collaborate with Ob-Gyn providers or staff. While the MedFT may be aware of biopsychosocial-spiritual health and relational well-being as a researcher and/or clinician, he or she only rarely or occasionally applies all of these health dimensions into practice. MedFTs at these levels are going to have some of the basic knowledge about the BPSS challenges associated with women's physical health but rarely introduce opportunities to consider biological, psychosocial, and spiritual dimensions of health into care delivery. They are likely to share pertinent information with other providers only as needed. In the vignette at the start of the chapter, a *Level 1 or 2* MedFT may have provided services to Jill, but may not have thought to expand the treatment to include Jill's partner. He or she may, too, have focused more specifically on Jill's emotional health rather than engaging in her BPSS well-being.

At *Level 3*, MedFTs are trained to apply a broad range of family therapy and BPSS interventions and conduct therapy in relation to a variety of women's health

Table 6.1 MedFTs in Obstetrics and Gynecology: Basic Knowledge and Skills

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Knowledge	Basic knowledge about BPSS approaches to obstetrical and gynecological services with an awareness of how physical, mental, and relational health interrelate. Familiar with Ob-Gyn as a profession, demonstrating an understanding of commonly seen diagnoses and treatments. Minimal awareness of treatment team members.	Some specific knowledge of how hormonal changes and medical conditions can influence both mental and relational health with ability to cite data about perinatal distress, infertility, pregnancy loss, pelvic pain, and interpersonal trauma. Knowledge of how to use electronic record to efficiently collaborate with colleagues from a distance. Awareness of treatment team members and their respective roles.	Working knowledge of specific team members and medical terminology (preeclampsia, gestational diabetes, etc.). Broad range of knowledge of research-informed individual, couple/family, and community approaches to care; incorporation of BPSS factors into treatment plans. When able, conducts research and policy/advocacy initiatives to advocate for BPSS-oriented care and inclusion of relational factors into Ob-Gyn settings.
Skills	Able to complete a BPSS conceptualization for patients and families experiencing miscarriage, stillbirth, preterm birth, pelvic pain, and various gynecologic conditions. Uses validation, empathy, and normalization with patients and families navigating life transitions (e.g., onset of menarche, pregnancy, menopause). Applies IPT and CBT techniques to individuals experiencing perinatal distress but within a broader systemic framework. Demonstrates minimal collaborative skills with professionals working in Ob-Gyn contexts; prefers to work as an individual practitioner model but able to refer as needed.	Systemic interventions are used alongside individually oriented modalities of psychotherapy to assist with management of psychological and relational distress, as well as medical compliance and agency in most cases. Facilitates communication between providers via written letters or electronic medical record messages to ensure providers are abreast to the patient or families treatment goals. Conducts a separate treatment plan from other providers with some related goals or interventions (i.e., "reduce subjective reports of pain" or "lower experiences of anxiety and increase social support postpartum").	Includes other treatment team members when conceptualizing and forming treatment plans, engaging in mutual learning. Implements systemic assessments via observational data, subjective reports, and use of enactments. Regularly integrates evidence-based measures to assess mental health among multiple family members (e.g., Edinburgh). Attends and contributes to team meetings to create a BPSS treatment plan for families seen in the Ob-Gyn context.

Table 6.2 MedFTs in Obstetrics and Gynecology: Advanced Knowledge and Skills

MedFT Healthcare Continuum Level	Level 4	Level 5
Knowledge	More advanced knowledge of common presenting problems, diagnoses, and treatments encountered in Ob-Gyn settings. Identifies self as a MedFT. Aware of advocacy needs for patients and families in Ob-Gyn settings. Attends to indicators of compassion fatigue among clinical team members.	Demonstrates command of evidence-based literature and research interprofessional collaboration and integrated behavioral healthcare models in treating Ob-Gyn-related diagnoses. Conveys clinical/research expertise with a variety of psychosocial, behavioral, and relational health diagnoses and interventions to Ob-Gyn patients, families, healthcare teams, community partners, administrators, researchers, policy makers, legislators, trainees, and/or supervisees.
Skills	Ability to design assessment guides or template for patient portals, electronic health records.	Supervises MedFTs or other health team members in integrated and traditional sessions with ability to recognize BPSS health factors that may not be known to the supervisee. Influences local, community, or state policies in relation to women's health disparities or necessary interventions that can maximize health and well-being.

experiences and concerns. They usually collaborate with providers, patients, and patients' support system members in order to ensure that treatment plans are systemically constructed and implemented. At *Level 3*, the MedFT (as described in the vignette) is working to collaborate on a variety of complex issues that may enter into an Ob-Gyn practice (such as a couple's loss via stillbirth). MedFTs at this level will also collaborate on other concerns using research-informed interventions on issues including intimate partner violence, depression, PPD, pain, and common psychosocial experiences that coincide with developmental changes across the lifespan.

MedFT research at this level may include intervention studies with women or dyads based on health experiences or conditions encountered in an Ob-Gyn practice. An example of such inquiry could include assessing for ways in which infertility influences both partners of a dyad or biopsychosocial-spiritual differences in PPD for mothers in comparison to fathers. In policy work, the *Level 3* MedFT advocates for healthcare policy that is inclusive of individuals, couples, families, and diverse populations and cultures across a wide range of BPSS issues pertaining to women's health. Practice recommendations from a MedFT may include requests for

inclusion of relational interventions when attending prenatal visits or promoting policies pertaining to assessment and intervention when intimate partner violence is flagged as present.

In this level, the MedFT is implementing research-informed practices with couples and families all the while maintaining an inclusion of BPSS questions that interface with the couple's or family's presenting concern. The MedFT is also likely attending conferences or community forums that attend to the policy needs of women.

At *Level 4*, MedFT clinicians and/or researchers integrate into healthcare contexts with diverse professionals. They are trained to apply a broad range of family therapy and BPSS interventions across both traditional and IBHC formats. They are confident with acute and chronic conditions, including treatment for patients struggling with substance use, past sexual trauma, and/or how expecting mothers manage gestational diabetes. These MedFTs consistently collaborate at each encounter with providers (colocated or integrated), patients, and patients' support system members, including brief assessments for depression, PPD, intimate partner violence, anxiety, and trauma. MedFTs at *Level 4* are skilled in using diverse family therapy and health-based theories, models, and interventions during each traditional and integrated behavioral healthcare visit. They are adept in managing biopsychosocial-spiritual concerns via once per year visits, as well as for patients who require multi-visit continuity of care. Given the volume of patients seen with diverse presenting concerns, these MedFTs are also aware of the ways in which demographics (e.g., ethnicity, religious affiliation, socioeconomics) may influence health disparities and indicated treatment options.

Researchers at *Level 4* consistently form interdisciplinary teams to study the reciprocal relationships between women's BPSS health status and couple/family support systems and the impact(s) of a MedFT or family therapy intervention(s) in traditional and integrated behavioral healthcare practice contexts. MedFT researchers would also work in tandem with medical researchers in Ob-Gyn contexts to further treatment options for health concerns such as pelvic pain, military sexual trauma (further discussed in the *Chapter 18*), or postpartum depression. Furthermore, MedFTs at this level commonly engage in cross-disciplinary collaborations such as with genetic counselors for women concerned about hereditary diseases, substance abuse counselors who assist in detox or treatment options for pregnant women who struggle with addiction, and/or with case managers who may need to investigate the safety of a newly born baby due to a mother's severe PPD with suicidal or homicidal ideation.

At *Level 5*, MedFTs are experienced at administrating and supervising other behavioral health providers in both traditional and integrated care models. In a clinical role, MedFTs collaborate routinely with providers, patients, and patients' support system members and have influence on templates that should be accessible in the electronic health record to account for psychosocial concerns (as described in the vignette at the start of the chapter), including social determinants. These MedFTs are proficient at family therapy and health-based theories, models,

and interventions in treating the primary concerns described throughout the chapter. They may develop and lead curriculum for providers on the team in relation to current research in biopsychosocial women's health, common trends in women's health literature, or research-informed ways to improve relational health between patient and her family system, patient-provider dyads, and provider-staff dynamics. These researchers routinely construct interdisciplinary teams to study the relationships between women's BPSS health status and couple/family support systems and/or the impact(s) of MedFT or family therapy intervention(s), including outcome studies for patients and their families/support systems receiving brief and traditional family therapy in both IBHC and conventional mental health settings on women's health issues.

Unique to *Level 5* are the abilities to serve as a supervisor and ambassador for women's health. MedFTs who serve in these roles are not only proficient at extending practice; they are aware that not all women have the same needs and thus advocate for best practices for lesbian and transwomen, racial and ethnic differences, and diverse age groups, recognizing the continuum of ability while honoring spiritual health differences in decision-making. Furthermore, research reflects an awareness of ethics, particularly with the complex circumstances of knowing how to best interface with women, given that so many of the physical exams require that the patient disrobe. With consideration for these elements, MedFTs at *Level 5* have learned—and constructed ways to maximize—patient flow and encounters in order to promote healthy BPSS care, research, and policies.

Research-Informed Practices

Ob-Gyn settings serve as a pivotal healthcare home for millions of women as they encounter diverse and complex transitions throughout the life cycle. Undoubtedly, intrapersonal, interpersonal, and cultural research must be examined when developing a comprehensive treatment plan or policies that promote women's health or reduce health disparities in IBHC contexts (El-Mohandes, Kiely, Gantz, & El-Khorazaty, 2011; Joseph et al., 2009). For MedFTs in IBHC settings, evidence-based research on brief relational and BPSS therapeutic techniques, such as interpersonal therapy, cognitive-behavioral therapy, or interpersonal psychoeducation communication strategies, hold utility in lessening psychological distress. These evidence-based approaches offer a focused way of conceptualizing and treating common symptoms (e.g., sleep disturbance, mood lability, negative thoughts of self or others, social isolation). Common concerns in Ob-Gyn contexts (e.g., pregnancy loss, transition to parenthood or menopause, and sexual difficulties) require research-informed skills and ability in detecting systemic patterns at the individual, family, and community levels.

Individual Approaches

Individual therapeutic skills hold value for many presenting problems encountered in Ob-Gyn contexts, such as preparation for or adjustment to a clinical procedure, sexual desire or pelvic pain issues, and—most notably—depression or anxiety among peri- or postnatal women. Core skills of validating or empathizing with patients remain crucial in both building rapport and ensuring a patient feels understood. Furthermore, psychoeducation regarding the overlay between biological, psychological, social, and spiritual factors can assist women in identifying strengths and concerns associated with their experiences. Psychoeducation that is grounded in a BPSS foundation also offers providers and the patient a multifactorial explanation for any current difficulties and, as such, guides appropriate treatment options. MedFTs in an Ob-Gyn practice should be aware of prevalence for common conditions, as well as evidence-based assessments and interventions. Table 6.3 provides examples of psychosocial symptoms that may be associated with having a baby, alongside treatment recommendations.

The two individual approaches most frequently cited in the remediation of perinatal distress include brief interpersonal therapy (IPT) and cognitive-behavioral therapy (CBT). IPT has been shown to be effective for perinatal depression, including PPD (O'Hara, Stuart, Gorman, & Wenzel, 2000; Weissman, Markowitz, & Klerman, 2000). Though IPT is typically completed in a therapist-patient relationship without involvement of a partner or spouse, IPT focuses primarily on interpersonal relationships as an avenue for change. IPT is the most efficacious therapy for depression, even more so than CBT (Cuijpers et al., 2008), holding particular value in circumstances of (a) grief and loss, (b) interpersonal disputes, and (c) role transitions (Stuart, 2012). The IPT clinician identifies relational conflict and limited social networks as key determinants of depressive symptomatology.

MedFTs can easily integrate common IPT tools of interpersonal inventory (e.g., description of key relationships), interpersonal circle (e.g., bullseye picture where relationships are visually depicted), and interpersonal formulation (e.g., graphing interface between BPSS) into an IBHC context (Stuart, 2012). To some degree, this approach can be thought of as systemic therapy with an individual, as treatment techniques involve a detailed account of interpersonal incidents followed by a communication analysis and role-playing techniques to change relational patterns. For postpartum women, this might involve identifying instrumental or emotional needs, exploring how to best communicate these needs to identified support persons, and problem-solving strategies to avoid criticism and defensiveness. It is not surprising that IPT provides particular benefits for women transitioning to motherhood or adjusting to loss, given that the chances for miscommunications as systemic homeostasis are disrupted.

Cognitive behavior therapy—an active, problem-focused approach—is another individual therapy commonly used in the treatment of perinatal distress (as well as non-perinatal mood and anxiety complaints). CBT is thought to have advantages over IPT in the treatment of anxiety, obsessive-compulsive disorder, and trauma- or

Table 6.3 Treatment Recommendations for Common Psychosocial Symptoms that may be Associated with having a Baby

Illness	Prevalence	Course of Illness	Clinical Symptoms	Treatment
Baby blues	50%–85%	Peak postpartum day 4–5 and typically remits within 2 weeks	• Irritability • Moodiness • Anxiety • Tearfulness • No functional impairment	No intervention usually necessary. Normalization and encourage self-care. Monitor for potential to progress to PPD.
Postpartum depression (PPD)	15%	Typically in the first 3 months after delivery but can be anytime in the postpartum period (up to 12 months)	• Depressed mood, sadness • Tearfulness • Loss of interest • Appetite change • Sleep disturbance • Feeling guilty, hopeless, or worthless • Trouble concentrating • Low energy • Suicidal thoughts	Dependent upon severity of the illness – Work-up for medical illnesses that present with psychiatric symptoms – Pharmacotherapy – Psychotherapy (IPT or CBT)
Postpartum anxiety	10%	Similar to PPD; can be anytime in the postpartum period (up to 12 months)	• Persistent, excessive worrying • Racing thoughts • Sleep disturbance • Appetite change • Inability to relax • Panic attacks • Fear that something bad will happen/is going to happen • Obsessions and/or compulsions	Dependent upon severity of the illness – Work-up for medical illnesses that present with psychiatric symptoms – Pharmacotherapy – Psychotherapy (CBT or ERP)
Postpartum psychosis	1–2/1000	Typically develops 48 hours −2 weeks after delivery	• Early symptoms include: – Sleep disturbance – Restlessness – Irritability • Progress to: – Rapid mood changes – Confusion – Disorganization – Auditory hallucinations – Delusions (usually associated with infant)	– Psychiatric emergency – Partial or full hospitalization – Risk for suicide and infanticide, thus conduct thorough safety assessment – Pharmacotherapy – Family psychoeducation

(Source: MGH Women's Mental Health Center, Postpartum Support International, Postpartum Progress, 2016)

stress-related disorders for perinatal women (Wenzel & Kleiman, 2015). In their detailed account of this approach for perinatal distress, Wenzel and Kleiman presented a biopsychosocial model for perinatal distress (similar to IPT's conceptualization with more focus on cognitions and psychological factors), highlighting how interactions of genetic vulnerability, neurochemical variability, and psychological vulnerability mediated through life stress (including relational factors) cue distress. According to these leading clinicians, CBT for perinatal distress works by evaluating unhelpful automatic thoughts, restructuring core beliefs, developing affective coping skills, and engaging in problem-solving or communication skills training. Some examples of clinical techniques include a patient challenging her thought of being a "terrible mother" or taking graded steps toward being close to her baby even if/when intrusive, ego-dystonic thoughts associated with OCD enter her mind. Of note, this would also be considered a subset of behavioral therapy, E/RP, referenced earlier in this chapter. It is recommended that a MedFT includes psychoeducation about the interplays between triggering stressors, automatic thoughts, emotional dysregulation, and behavioral responses, especially since cognitive distortions often pertain to relational content or worldviews.

CBT's utility extends beyond perinatal distress to many other mental health conditions that are outlined in other chapters within this text. One area that deserves particular mention is the role of cognitions in pelvic pain. Understanding the interplays between psychological appraisal of pain and ongoing symptomatology is a necessary step for the treatment team. The Pain Catastrophizing Scale (Sullivan, Bishop, & Pivik, 1995) outlines three core factors related to pain-related catastrophizing: (a) rumination, (b) magnification, and (c) helplessness. Assessing the cognitive stance toward pain seems to be a valuable first step prior to implementation of individual and relational treatment protocols. Furthermore, inquiry into the following individual psychological factors is important: somatic hypervigilance, fear of pain, negative attitudes about sexuality, distraction from sexual cues, anxiety, negative causal attributions for the pain, feelings of low self-efficacy in coping with pain, and depressive symptoms (Desrochers, Bergeron, Landry, & Jodoin, 2008; Meana, 2012). A recent randomized control trial (RCT) tested the efficacy of cognitive-behavioral couple therapy compared to topical lidocaine for provoked vestibulodynia (PVD), a frequent source of chronic genital pain (Corsini-Munt et al., 2014). While current theories and best practices guide MedFT clinicians toward application of CBT to pelvic or genital pain conditions, future relational research, such as the RCT referenced, will undoubtedly inform the specifics of how to involve partners in treatment of these debilitating conditions. Clinicians interested in learning more about the current treatments for female sexual pain disorders can turn to a recently published systematic review by Al-Abbadey et al. (2016).

While IPT and CBT have provided MedFTs with a roadmap to addressing psychological distress in practice, other clinical researchers have discussed the value of a strengths-based approach to bereavement or other adversity. Calhoun and Tedeschi (2014) have written extensively about the concept of posttraumatic growth (PTG), which is positive psychosocial-spiritual change resulting from adversity. Emerging research over the last several years underscore the importance of assessing PTG and

coping strategies in cases of unexpected perinatal loss and pregnancy termination for fetal abnormality (Black & Wright, 2012; LaFarge, Mitchell, & Fox, 2017). Using their model, MedFTs can assess, punctuate, and amplify personal strengths, improved relationships, spiritual changes, and experiences of gratitude as a result of significant and complex circumstances. As MedFTs tend to operate from both a relational and strengths-based stance, attention to the resilience and growth aspects of the transitionary experiences of Ob-Gyn patients seems crucial.

Family Approaches

Emerging science is exploring the utility of including partners and families in a variety of interventional studies (Corsini-Munt et al., 2014). Considerable research has emerged citing the role of partner responses (e.g., solicitousness, negative, facilitative) and societal/cultural factors of religiosity and stigma in genito-pelvic pain (Meana, Maykut, & Fertel, 2015). Existing knowledge guides clinicians to enact facilitative patterns among partners where flexible sexual scripts can build intimate cohesion, for instance, helping a partner know how to verbally or nonverbally adapt to painful sexual scenarios (e.g., "It seems like this is difficult for us; what if we touch in this way instead?") rather than halting all touch or responding critically to a situation. Healthy communication about wants and needs are vital for treatment success. Additional relational and research-informed practices for genito-pelvic pain and other sexual dysfunctions can be found in Hertlein, Weeks, and Gambescia's (2015) recently updated comprehensive guide to sexual health, entitled *Systemic Sex Therapy.* Using this text or a similar resource, MedFTs should familiarize themselves with information about the female sexual response cycle, notably how desire, arousal, and orgasm interact with couple, intergenerational, and societal/cultural factors. Psychoeducation, goal setting, behavioral techniques (e.g., graded exposure, sensate focus), and empathetic attunement are common goals across relationally focused sex therapy (Hertlein et al., 2015).

While there is a growing literature on the relational implications of various Ob-Gyn concerns (e.g. bereavement, STIs, menopause), the efficacy of marital/couple and family therapy interventions for couples dealing with infertility also deserves specific mention. As far back as 2001, Deborah Gerrity published a biopsychosocial theory of infertility. In her paper, treatment suggestions for couples included noting differences in coping styles, exploring dissimilarities in boundary wishes (sustaining privacy versus seeking support), and uniting couples around decision-making about things that they can control. As time has progressed, clinicians have applied evidence-based couple therapy as a way to improve sexual satisfaction, marital adjustment, and emotional distress for those dealing with infertility (Soleimani et al., 2015; Soltani, Shairi, Roshan, & Rahimi, 2014). These investigators found that when emotionally focused couple therapy (EFT) protocols were applied to infertile couples, significant improvements were found in relation to couples' satisfaction, cohesion, and affectional expression (Soleimani et al., 2015).

EFT also reduced rates of depression, anxiety, and stress for men and women who were coping with infertility (Soltani et al., 2014). Advantages of relational therapy are not limited to EFT, either; a recent meta-analysis of 39 studies documented that couple interventions, including cognitive-behavioral couples therapy and mindfulness-based interventions, appear to be efficacious at both lowering mental health concerns and improving pregnancy rates (Frederiksen, Farver-Vestergaard, Skovgard, Ingerslev, & Zachariae, 2015).

Community Approaches

Recognizing the need for communion, manifested through contact, openness, and union (Bakan, 1966), during profound life transitions can help to promote efforts that connect women to community resources as they are navigating the new role of motherhood. Centering Pregnancy is a form of group prenatal care that was first described in the literature the late 1990s (Rising, 1998). A group of 8–12 pregnant women met together for interactive learning and community building (Alliman, Jolles, & Summers, 2015); below are the essential elements required for the program:

1. Health assessment occurs within the group space
2. Women are involved in self-care activities
3. A facilitative leadership style is used
4. Each session has an overall plan
5. Attention is given to the core content; emphasis may vary
6. There is stability of group leadership
7. Group conduct honors the contribution of each member
8. The group is conducted in a circle
9. Group composition is stable, but not rigid
10. Group size is optimal to promote the process
11. Involvement of family support people is optional
12. Opportunity for socialization within the group is provided
13. There is ongoing evaluation of outcomes

Centering Pregnancy groups also provide individual abdominal assessments (performed behind a curtain). Contexts are selected so that pelvic exams and/or MedFT sessions that include sensitive topics can be performed in confidential rooms away from the group. Sessions are longer than traditional models of prenatal care—and the relationships that are formed during these sessions may become an essential part of an expecting mother's support system. These groups may be even more important for women who have been raised in or align with communal societies rather than intra-individually focused societies. Collectively, research has found that those participating in such care show a decrease in the number of preterm births and evidence both positive individual- and community-level outcomes (Magant & Dodgson, 2011).

Freestanding birth centers are another model of maternity care where women receive prenatal care, labor, and give birth in the same facility with midwives. These prenatal visits are also longer than traditional models of care, allowing for education and relationship building between pregnant women and midwives. Freestanding birth centers maintain standards set up by the American Association of Birth Centers (AABC) and have shown "improved health outcomes, cost savings, and increased patient satisfaction" (Alliman et al., 2015, p. 244).

Conclusion

Opportunities for IBHC in Ob-Gyn contexts via the inclusion of MedFT support endless pathways to improve BPSS health for women and their families. The realm of care provided in Ob-Gyn practices reaches from the prevention of unhealthy behaviors and unintended pregnancies to interventions that can increase the likelihood for healthy relationships between partners, between parent(s) and child, and in patients' BPSS well-being. MedFTs are able to contribute their knowledge and skills in tandem with Ob-Gyn providers to improve psychosocial factors associated with diverse medical and mental illnesses, complex relational issues, and trauma. Evidence through research-informed practices and clinical research outcomes continue to support the urgency of having this field integrated into Ob-Gyn practices for the betterment of women's BPSS health.

Reflection Questions

1. How will you prepare yourself to begin a collaborative relationship with patients and/or providers in an Ob-Gyn context?
2. What beliefs do you have about sexual health, common birthing practices, congenital abnormalities, adoption, abortion, and death of a fetus or parent during pregnancy or delivery?
3. What parenting or intergenerational issues could arise that would be a strength or impede MedFT services or IBHC? Consulting your standard of ethics, federal regulations pertaining to privacy, and/or ongoing meetings with supervisors is a great way to stay in-check regarding this question.
4. What evidence-based or outcome research are you familiar with that may be of assistance to clinical services with families receiving care in Ob-Gyn contexts?

Glossary of Important Terms for Care in Obstetrics and Gynecology

Breech presentation When the fetus is positioned inside the uterus in a manner whereby its feet or buttocks would—without intervention—deliver first (instead of the head).

C-section (Cesarean birth) A surgical delivery of a baby through incisions made in the abdomen and uterus.

Cervix The opening to the uterus, located at the top of the vagina.

D&C (dilation and curettage) A surgical procedure for removal of tissue from inside the uterus by opening the cervix and inserting an instrument into the uterus.

Ectopic pregnancy Also known as a mislocated pregnancy; symptoms include unexpected vaginal bleeding and cramping. The fetus may grow enough to rupture the fallopian tube (typically after about 6–8 weeks), whereby a woman usually feels severe pain in her lower abdomen. If the tube ruptures later (after about 12–16 weeks), the risk of death for the woman is increased because the fetus and placenta are larger and lead to an increased loss of blood. In most women, the fetus and placenta from an ectopic pregnancy must be surgically removed.

Hysterectomy A surgery for removal of the uterus. It is termed a "total hysterectomy" if the cervix is removed with the uterus.

Placenta previa A condition that occurs in about one in every 200 deliveries; it refers to when the placenta is mostly or completely covering the cervix, in the lower (rather than upper) part of the uterus. Placenta previa can cause painless bleeding from the vagina that suddenly begins late in pregnancy necessitating emergent delivery. It is a risk for maternal and fetal death due to blood loss.

Preeclampsia An illness that occurs in pregnancy or after delivery where a woman has high blood pressure and symptoms of organ injury or dysfunction. Some of these symptoms include an abnormal amount of protein found in the urine, abnormal liver or kidney function, vision changes, decreased number of platelets, upper abdominal pain, fluid found in the lungs, and severe headache. (note: Eclampsia is an extension of preeclampsia, resulting in maternal seizures.)

Preterm delivery When a baby is born before week 37 of the pregnancy.

Preterm labor Also called premature labor; it refers to when uterine contractions occur before 37 weeks of pregnancy.

Previable delivery A delivery prior to 23 weeks (22 weeks in some facilities).

Sexually transmitted infections/diseases (STI/D) Some women may not know that they are carrying an STI/D; this becomes an even more of complicated issue during pregnancy or at the time of delivery. Some STI/Ds are more dangerous for the fetus than others, especially when considering vaginal deliveries. Some hospitals are using rapid human immunodeficiency virus (HIV) testing during labor and delivery for pregnant women who were not tested previously during pregnancy. If a woman is found to be HIV-infected, providers are then able to begin antiretroviral therapy immediately to prevent perinatal transmission.

Thromboembolic disease In the United States, thromboembolic disease is the leading cause of death in pregnant women. It occurs when blood clots form in blood vessels that travel through the woman's bloodstream and block an artery. This disease most commonly occurs 6–8 weeks after delivery. The risk is much greater after a cesarean section than after vaginal delivery.

Additional Resources

Literature

Coady, D., & Fish, N. (2011). *Healing painful sex: A woman's guide to confronting, diagnosis, and treating sexual pain.* Berkley, CA: Seal Press.
Murkoff, H. & Mazel, S. (2016). *What to expect when you are expecting* (5th ed.). New York, NY: Workman Publishing Company. (note: This text is also available in Spanish).
Wenzel, A. (2014). *Coping with infertility, miscarriage, and neonatal loss: Finding perspective and creating meaning.* Washington, DC: American Psychological Association.

Measures/Instruments

Edinburgh Postnatal Depression Scale (EPDS). http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf
Pain Catastrophizing Scale. http://sullivan-painresearch.mcgill.ca/pcs.php
Perinatal Anxiety Screening Scale (PASS). http://www.kemh.health.wa.gov.au/services/pmcls/docs/PASSAdministrationandScoringGuidelines.pdf
Postpartum Bonding Questionnaire (PBQ). https://www.scribd.com/document/284790115/Postpartum-Bonding-Questionnaire
Postpartum Depression Screening Scale (PDSS). http://www.wpspublish.com/store/p/2902/postpartum-depression-screening-scale-pdss
Postpartum Distress Measure (PDM). http://postpartumstress.com/for-professionals/assessments/

Organizations/Associations

American College of Nurse-Midwives. www.midwife.org
American Congress of Obstetricians and Gynecologists. www.acog.org
American Gynecological and Obstetrical Society. www.agosonline.org
Association of Women's Health, Obstetric and Neonatal Nurses. www.awhoon.org
Compendium of Centering. https://www.centeringhealthcare.org/why- centering/evaluation-research/
International Lactation Consultant Association. www.ilca.org
Massachusetts General Hospital Center for Women's Mental Health. www.womensmentalhealth.org

Office of Women's Health, U.S. Department of Health and Human Services. www.womenshealth.gov
Postpartum Progress. www.postpartumprogress.com
Postpartum Support International. www.postpartum.net
Share: Pregnancy & Infant Loss Support. http://nationalshare.org/

References[1]

Ahangari, A. (2014). Prevalence of chronic pelvic pain among women: An updated review. *Pain Physician*, *17*, 141–147. http://www.diva-portal.org/smash/get/diva2:770659/FULLTEXT01.pdf

Ahuja, S. P., & Hertweck, S. P. (2010). Overview of bleeding disorders in adolescent females with menorrhagia. *Journal of Pediatric Adolescent Gynecology*, *23*, S15–S21. https://doi.org/10.1016/j.jpag.2010.08.006

*Al-Abbadey, M., Liossi, C., Curran, N., Schoth, D. E., & Graham, C. A. (2016). Treatment of female sexual pain disorders: A systematic review. *Journal of Sex & Marital Therapy, 42,* 99–142. https://doi.org/10.1080/0092623X.2015.1053023.

Alijotas-Reig, J., & Garrido-Gimenez, C. (2013). Current concepts and new trends in the diagnosis and management of recurrent miscarriage. *Obstetrical & Gynecological Survey*, *68*, 445–466. https://doi.org/10.1097/OGX.0b013e31828aca19

Alliman, J., Jolles, D., & Summers, L. (2015). The innovation imperative: Scaling freestanding birth centers, centering pregnancy, and midwifery-led maternity health homes. *Journal of Midwifery & Women's Health*, *60*, 244–249. https://doi.org/10.1111/jmwh.12320

American Congress of Obstetricians and Gynecologists. (2005). *The scope of practice of obstetrics and gynecology*. Retrieved from https://www.acog.org/About-ACOG/Scope-of-Practice

American Congress of Obstetricians and Gynecologists. (2015). *Frequently asked questions*. Retrieved from https://www.acog.org/Patients/FAQs/Early-Pregnancy-Loss#how

*American Congress of Obstetrics and Gynecology (2015). Practice bulletin number 150: Early pregnancy loss. *Obstetrics & Gynecology, 125,* 1258–1267. https://doi.org/10.1097/01.AOG.0000465191.27155.25

American College of Obstetrics and Gynecologists. (2015). *The menopause years*. http://www.acog.org/Patients/FAQs/The-Menopause-Years

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM 5*. Washington, D.C: American Psychiatric Association.

Bakan, D. (1966). *The duality of human existence: Isolation and communion in western man*. Boston, MA: Beacon.

Bergink, V., Burgerhout, K. M., Koorengevel, K. M., et al. (2015). Treatment of psychosis and mania in the postpartum period. *American Journal of Psychiatry*, *172*, 115–123. https://doi.org/10.1176/appi.ajp.2014.13121652

Berishaj, K. (2017). Sexual assault. In K. Schuiling and F. Likis (Eds.), *Women's gynecologic health* (3rd ed., pp. 327–356). Burlington, MA: Jones & Bartlett Learning.

Black, B. P., & Wright, P. (2012). Posttraumatic growth and transformation as outcomes of perinatal loss. *Illness, Crisis, & Loss*, *20*, 225–237. https://doi.org/10.2190/IL.20.3.b

*Calhoun, L. G., & Tedeschi, R. G. (2014). *Handbook of posttraumatic growth: Research and practice.* New York, NY: Psychology Press.

Cason, P. (2017). Sexuality and sexual health. In K. Schuiling and F. Likis (Eds.), *Women's gynecologic health* (3rd ed., pp. 191–208). Burlington, MA: Jones & Bartlett Learning.

[1] Note: References that are prefaced with an asterisk are recommended readings.

Centers for Disease Control and Prevention (2016). *Sexually transmitted disease surveillance 2015*. https://www.cdc.gov/nchhstp/newsroom/2016/std-surveillance-report-2015-press-release.html

*Coady, D., & Fish, N. (2011). *Healing painful sex: A woman's guide to confronting, diagnosis, and treating sexual pain*. Berkley, CA: Seal Press.

Corsini-Munt, S., Bergeron, S., Rosen, N. O., Steben, M., Mayrand, M. H., Delisle, I., … Santerre-Baillargeon, M. (2014). A comparison of cognitive-behavioral couple therapy and lidocaine in the treatment of provoked vestibulodynia: Study protocol for a randomized control trial. *Trials*, *15*, 506–517. https://doi.org/10.1186/1745-6215-15-506

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh postnatal depression scale. *British Journal of Psychiatry*, *150*, 782–786. https://doi.org/10.1192/bjp.150.6.782

Cuijpers, P., van Straten, A., Andersson, G., & Van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting Clinical Psychology*, *76*, 909–922. https://doi.org/10.1037/a0013075

Cunningham, G., Leveno, K., Bloom, S., Spong, C., Sashe, J., Hoffman, B., … Sheffield, J. (2014). Stillbirth. In F. Cunningham, K. Leveno, S. Bloom, C. Spong, J. Dashe, B. Hoffman, B. Casey, & J. Sheffield (Eds.), *Williams obstetrics* (24th ed., pp. 661–667). New York, NY: McGraw Hill Education.

Dehlendorf, C., Krajewski, C., & Borrero, S. (2014). Contraceptive counseling: Best practices to ensure quality communication and enable effective contraceptive use. *Clinical Obstetrics and Gynecology*, *57*, 659–673. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4216627/

Desrochers, G., Bergeron, S., Landry, T., & Jodoin, M. (2008). Do psychosexual factors play a role in the etiology of provoked vestibulodynia? A critical review. *Journal of Sex and Marital Therapy*, *34*, 198–226. https://doi.org/10.1080/00926230701866083

Ellis, S. A., Wojnar, D. M., & Pettinato, M. (2014). Conception, pregnancy, and birth experiences of male and gender variant gestational parents: It's how we could have a family. *Journal of Midwifery & Women's Health*, *60*, 62–69. https://doi.org/10.1111/jmwh.12213

El-Mohandes, A. A., Kiely, M., Gantz, M. G., & El-Khorazaty, M. N. (2011). Very preterm birth is reduced in women receiving an integrated behavioral intervention: A randomized controlled trial. *Maternal and Child Health Journal*, *15*, 19–28. https://doi.org/10.1007/s10995-009-0557-z

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*, 129–136. https://doi.org/10.1016/b978-0-409-95009-0.50006-1

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Family Medicine*, *137*, 535–544. https://doi.org/10.1176/ajp.137.5.535

Fairbrother, N., & Woody, S. R. (2008). New mothers' thoughts of harm related to the newborn. *Archives of Women's Mental Health*, *11*, 221–229. https://doi.org/10.1007/s00737-008-0016-7

Finer, L. B., & Zolna, M. R. (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006. *Contraception*, *84*, 478–485. https://doi.org/10.1016/j.contraception.2011.07.013

*Hertlein, K. M., Weeks, G. R., & Gambescia, N. (2015). *Systemic sex therapy (2nd ed.)*. New York, NY: Routledge.

Hodgson, J., Lamson, A., Mendenhall, T., & Tyndall, L. (2014). Introduction to medical family therapy: Advanced applications. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 1–9). New York, NY: Springer.

Jordan, R. (2014). Perinatal loss and grief. In R. Jordan, J. Engstrom, J. Marfell, and C. Farley (Eds.), *Prenatal and postnatal care: A woman-centered approach* (pp. 409–415). Iowa: John Wiley & Sons.

Joseph, J. G., El-Mohandes, A. A., Kiely, M., El-Khorazaty, M. N., Gantz, M. G., Johnson, A. A., … Subramanian, S. (2009). Reducing psychosocial and behavioral pregnancy risk factors: Results of a randomized clinical trial among high-risk pregnant African American women. *American Journal of Public Health*, *99*, 1053–1062. https://doi.org/10.2105/AJPH.2007.131425

*Frederiksen, Y., Farver-Vestergaard, I., Skovgard, N. G., Ingerslev, H. J., & Zachariae, R. (2015). Efficacy of psychosocial interventions for psychological and pregnancy outcomes in infer-

tile women and men: A systematic review and meta-analysis. *BMJ Open, 5,* 1–18. https://doi.org/10.1136/bmjopen-2014-006592

Lafarge, C., Mitchell, K., & Fox, P. (2017). Posttraumatic growth following pregnancy termination for fetal abnormality: The predictive role of coping strategies and perinatal grief. *Anxiety, Stress, & Coping*, 1–15. https://doi.org/10.1080/10615806.2016.1278433

Lamson, A., & Phelps, K. (2011). Labor and delivery. In *Clinical updates for family therapists: Research and treatment approaches for issues affection today's families (Volume 4)*. Alexandria, VA: American Association for Marriage and Family Therapy.

*Luk, B. H. K., & Loke, A. Y. (2015). The impact of infertility on the psychological well-being, marital relationships, sexual relationships, and quality of life of couples: A systematic review. *Journal of Sex and Marital Therapy*, *41,* 610–625. https://doi.org/10.1080/0092623X.2014.958789

Magant, A., & Dodgson, J. E. (2011). Centering pregnancy: An integrative literature review. *Journal of Midwifery & Women's Health*, *56*, 94–102. https://doi.org/10.1111/j.1542-2011.2010.00021.x

Martin, J. A., Hamilton, B. E., Ventura, S. J., Osterman, M. J., Wilson, E. C., Mathews, T. J., et al. (2011). Births: Final data for 2010. *National Vital Statistics Reports*, *61*, 1–72. http://waterbirthsolutions.com/Downloadables/1.pdf

Massachusetts General Hospital Center for Women's Mental Health. (2017). *Homepage*. https://womensmentalhealth.org/?doing_wp_cron=1511581621.1843678951263427734375

Meana, M. (2012). *Sexual dysfunction in women*. Cambridge, MA: Hogrefe Press.

Meana, M., Maykut, C., & Fertel, E. (2015). Painful intercourse: Genito-pelvic pain/penetrative disorder. In K. M. Hertlein, G. R. Weeks, and N. Gambescia (Eds.), *Systemic sex therapy* (2nd ed., pp. 191–209). New York, NY: Routledge.

Monga, M., Alexandrescu, B., Katz, S. E., Stein, M., & Ganiats, T. (2004). Impact of infertility on quality of life, marital adjustment and sexual function. *Urology*, *63*, 126–130. https://doi.org/10.4103/0974-1208.86088

*Murkoff, H. & Mazel, S. (2016). *What to expect when you are expecting* (5th ed.). New York, NY: Workman Publishing Company.

Murphy, P., Hewitt, C., & BeLew, C. (2017). Contraception. In K. Schuiling and F. Likis (Eds.), *Women's gynecologic health* (3rd ed., pp. 209–260). Burlington, MA: Jones & Bartlett Learning.

National Institute of Mental Health (NIMH). (2015). *Major depression among adolescents*. https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml

Newport, D. J., Fernandez, S. V., Juric S., & Stowe, Z. N. (2009). Psychopharmacology during pregnancy and lactation. In A. F. Schatzberg and C. Nemeroff (Eds.). *The American psychiatric publishing textbook of psychopharmacology (4th Ed.).* http://www.psychiatryonline.org

Office of Women's Health, US Department of Health and Human Services (2017). *Homepage*. https://www.womenshealth.gov/

O'Hara, M. W., Stuart, S., Gorman, L., & Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry*, *57*, 1039–1045. https://doi.org/10.1002/cpp.1778

Osborne, K. (2017). Health promotion. In K. Schuiling and F. Likis (Eds.), *Women's gynecologic health* (3rd ed., pp. 61–76). Burlington, MA: Jones & Bartlett Learning.

*Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. *Journal of the American Medical Association, 303,* 1961–1969. https://doi.org/10.1001/jama.2010.605

Postpartum Support International. (2016). *You are not alone!* Retrieved from http://www.postpartum.net/

Rising, S. S. (1998). Centering pregnancy: An interdisciplinary model of empowerment. *Journal of Nurse Midwifery*, *43*, 46–54. https://doi.org/10.1016/S0091-2192(97)00117-1

Shin, J. H., & Howard, F. M. (2011). Management of chronic pelvic pain. *Current Pain and Headache Reports*, *15*, 377–385. https://doi.org/10.1007/s11916-011-0204-4

Soleimani, A. A., Najafi, M., Ahmadi, K., Javidi, N., Kamka, E. H., & Mahboubi, M. (2015). The effectiveness of emotionally focused couples therapy on sexual satisfaction and marital adjustment of infertile couples with marital conflicts. *International Journal of Fertility and Sterility*, *9*, 393–402. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4671378/

Soltani, M., Shairi, M. R., Roshan, R., & Rahimi, C. (2014). The impact of emotionally focused therapy on emotional distress in infertile couples. *International Journal of Fertility and Sterility*, *7*, 337–344. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3901179/pdf/Int-J-Fertil-steril-7-337.pdf

Stein, S. L. (2013). Chronic pelvic pain. *Gastroenterology clinics of North America*, *42*, 785–800. https://doi.org/10.1016/j.gtc.2013.08.005

Stephenson, M., Awartani, K., & Robinson, W. (2002). Cytogenetic analysis of miscarriages from couples with recurrent miscarriage: A case-control study. *Human Reproduction*, *17*, 446–451. https://doi.org/10.1093/humrep/17.2.446

Stuart, S. (2012). Interpersonal psychotherapy. In M. J. Dewan, B. N. Steenbarger, and R. P. Greenberg (Eds.), *The art and science of brief psychotherapies: An illustrated guide* (pp. 157–193). Arlington, VA: American Psychiatric Publishing.

Sullivan, M. J. L., Bishop, S. R., & Pivik, J. (1995). The pain catastrophizing scale: Development and validation. *Psychological Assessment*, *7*, 524–532. https://doi.org/10.1037/1040-3590.7.4.524

Suri, R., Lin, A. S., Cohen, L. S., & Altshuler, L. L. (2014). Acute and long-term behavioral outcome of infants and children exposed in utero to either maternal depression or antidepressants: A review of the literature. *Journal of Clinical Psychiatry*, *75*, 1142–1152. https://doi.org/10.4088/JCP.13r08926

*Tripp, D. A., & Nickel, J. C. (2013). Pain clinical updates: Psychosocial aspects of chronic pelvic pain. *International Association for the Study of Pain, 21*, 1–7. https://www.iasp-pain.org/files/Content/ContentFolders/Publications2/PainClinicalUpdates/Archives/PCU_21-1.pdf

Uguz, R., & Ayhan, M. G. (2011). Epidemiology and clinical features of obsessive-compulsive disorder during pregnancy and postpartum period: A review. *Journal of Mood Disorders*, (4), 178–186. https://doi.org/10.5455/jmood.20111219111846

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York, NY: Basic Books.

*Wenzel, A. (2014). *Coping with infertility, miscarriage, and neonatal loss: Finding perspective and creating meaning*. Washington, DC: American Psychological Association.

*Wenzel, A., & Kleiman, K. (2015). *Cognitive behavioral therapy for perinatal distress.* New York, NY: Routledge.

Wheaton, M. G., Galfalvy, H., Steinman, S. A., Wall, M. M., Foa, E. B., & Simpson, H. B. (2016). Patient adherence and treatment outcome with exposure and response prevention for OCD: Which components of adherence matter and who becomes well? *Behaviour Research and Therapy*, *85*, 6–12. https://doi.org/10.1016/j.brat.2016.07.010

Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs: The heart of healing in families and illness*. New York, NY: Basic Books.